CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/30/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155785			LDING	NSTRUCTION 00	COM	TE SURVEY TPLETED 5/2011	
	PROVIDER OR SUPPLIER		•	714 S E	DDRESS, CITY, STATE, ZIP C ICKHOFF RD VILLE, IN47712	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F0000	(PSR) to the Invo IN00096308 con 2011. Complaint IN000 Unrelated deficie	ovember 15 and 16, 2011 012448 : 155785	FC	000			
	Census bed type: SNF: 33 Residential: 55 Total: 88 Census payor typ Medicare: 25 Other: 63 Total: 88 Sample: 10 These deficiencies						
LABORATOR	Y DIRECTOR'S OR PROV	VIDER/SUPPLIER REPRESENTATIVE'S SI	GNATURI	Ξ	TITLE		(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

TN4712

Facility ID:

012448

If continuation sheet

PRINTED: 11/30/2011 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER: 155785	(X2) MULTIPLE CO A. BUILDING B. WING	00	COMPLETED 11/16/2011
	ROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP CODE EICKHOFF RD VILLE, IN47712	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	Quality review of Cathy Emswiller	ompleted 11/17/11 RN			
F0282 SS=E	facility must be pro- in accordance with plan of care. Based on observa- record review, th medications were prescribed by the residents reviewe	e physician, for 4 of 9 ed during medication le of 10. Residents D, B,	F0282	F282Resident D's MAR and physician orders were review with RN #1. Staff that adminimedication to him have been inserviced on these orders as as being checked off for propadministration of them.Completion Date 11-30-11Resident B's MAR hen been reviewed with RN #1. Sthat administer medication to them and have been checked	ster s well per nas Staff

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TN4712 Facility ID:

012448

If continuation sheet

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155785	B. WIN			11/16/20	011
			D. 1121		ADDRESS, CITY, STATE, ZIP CODE	l	
NAME OF I	PROVIDER OR SUPPLIEF	8		1	EICKHOFF RD		
WEST R	IVER HEALTH CAN	MPUS .			VILLE, IN47712		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	1. On 11/15/11 a	t 12:10 P.M., RN # 1			for proper administration of t	hese	
	indicated she wa	s going to give Resident			meds.Completion Date		
	D his "upon risi	ng" medications. RN # 1			11-30-11Resident A's MAR been reviewed with RN #1.		
	_	nt D had been in the			that administer medications		
		reakfast time, and she			been checked off on proper		
	_	to pass medications in			administration and the reside	ent	
		RN # 1 indicated she "			has been instructed on the		
	_				correct order for the		
	-	with therapy" sometimes			medication.Completion Date		
	to give the reside	ent his medications.			11-30-11Resident E's MAR been reviewed with RN #1 a		
					other staff that administer he		
	RN # 1 proceede	ed to prepare medications			meds for check off of proper		
	with labels which	h indicated: Zinc 50 mg			procedure and as		
	in am with break	fast, Glucotrol 5 mg [for			ordered.Completion Date		
	blood sugar] in a	ım before breakfast, and			11-30-11No other residents		
		mg [for blood sugar]			affected by the deficient practice	ctice	
		The Administrator was			and through inservicing and competency completion will		
		me that RN # 1 was			ensure that medications are		
					administered as they are ord	dered	
		ninister the resident these			and documented		
		l indicated she would			timely.Completion Date		
		r of Nursing [DON]. Prior			11-30-11Licensed nursing s		
		ving, RN # 1 indicated it			inserviced on proper medica		
	1	give the Glucotrol and			administration procedures a documentation of	na	
	Glucophage, sine	ce "the order says before			completion.Completion Date	,	
	breakfast, and it	is before lunch." The			11-30-11DHS/Designee will		
	DON then arrive	ed, and instructed RN # 1			observe 1 nurse per day dur	ing	
		cations, and inform the			med administration rotating	shifts	
	physician.	•			and hallways, and fill out		
	1 5				observation report upon		
	The clinical reco	ord of Resident D was			completion with identified concerns related to dosage,		
		15/11 at 12:30 P.M.			technique, timeframes,		
					documentation, etc. Audits	will	
	_	ded, but were not limited			be for 15days, then 1 per we		
		Hypertension. Physician			for 30 days, then 1 monthly.		
		vember 2011, indicated:			Pharmacist will also random	•	
	"Zinc 50 mg, Gi	ve 1 capsule by mouth in			observe 1 nurse med pass p	per	

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155785			LDING	NSTRUCTION 00	(X3) DATE COMPL 11/16/2	ETED	
	PROVIDER OR SUPPLIER		•	714 S E	ADDRESS, CITY, STATE, ZIP CODE		
WESTR	IVER HEALTH CAN	//PUS		EVANS	VILLE, IN47712		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	the morning with mg, Give 1 table morning before I [diabetes mellitu tablet, Give 1 tal morning before I 2. On 11/15/11 at medication pass, administer Resident of Resident Diagnoses included to, History of CV Hypertension. A initially dated 2/ November 2011 "Norvasc 5 mg Codaily upon rising [hypertension]." observed to admit the earlier medical was reviewed at "after rising" meas given.	a breakfast, Glucotrol 5 at by mouth in the breakfast for DM as], Glucophage 500 mg blet by mouth every breakfast." at 9:55 A.M., during a a.RN # 1 was observed to alent B medications. 0:45 A.M., the clinical and B was reviewed. aled, but were not limited and by A [stroke] and by Physician's order, and and on the current by a for HTN by A I had not been been inister the Norvasc with attion pass. The MAR by that time, and none of the by dications were initialed 2:30 P.M., during by M. # 1, she did not			month.Results of audits will It forwarded to QA committee monthly x 6 months and quathereafter.	ре	
	Norvasc had not 3. On 11/15/11 a	at 10:40 A.M., during					
	observation of a	medication pass, RN # 1					

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155785	B. WIN	G		11/16/2	011
NAME OF I	PROVIDER OR SUPPLIER	3	•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	_	
					EICKHOFF RD		
WEST R	IVER HEALTH CAN	MPUS		EVANS	VILLE, IN47712		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG	†	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
		administer medications					
		one of the medications					
		50 inhaler, in which the					
		1 puff every 12 hours."					
	_	inhaler to the resident,					
		proceeded to give himself					
	2 puffs of the inl	naler.					
		1 CD :1 . A					
		ord of Resident A was					
		15/11 at 11:35 A.M. A					
		r, initially dated 8/19/11					
		nt November 2011 orders,					
	-	nir 100/50 Give 1 puff					
	1	nours." The resident 's					
		wed at that time, and					
		ident was to receive the					
	inhaler "Upon ri	sing " and "HS"					
	[bedtime].						
	4 On 11/15/11 s	at 2:15 P.M., during					
		medication pass, RN # 1					
		administer Resident E					
		ich included Trental 400					
	1	disorders]. When RN # 1					
		ent 's room, the resident					
		I not get my Benefiber					
	-	't receive it this morning."					
	-	cked the MAR, and					
		resident Benefiber 1					
	_	ndicated at that time that					
		at an entry on the MAR					
		"Benefiber, refuses,					
	_	" and so didn't give it. An					
	additional entry	on the MAR indicated,					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155785		A. BUII	LDING	ONSTRUCTION 00	(X3) DATE COMPL 11/16/2	ETED	
NAME OF A			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
	PROVIDER OR SUPPLIEF				ICKHOFF RD		
WEST R	IVER HEALTH CAN	MPUS		EVANS	VILLE, IN47712		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
		eket BID [with] meals,		0			5.112
	Breakfast, Suppo						
	The clinical reco	ord of Resident E was					
	reviewed on 11/	15/11 at 2:45 P.M.					
	Physician orders	on the November 2011					
		ded: "Trental 400 mg po					
	-	daily] upon rising,					
		l "Benefiber BID [twice					
	daily]."						
	5. On 11/15/11 a	st 2:00 D.M. tha					
		rovided the current facility					
	policy on "Speci	•					
		Procedures," dated 2/1/10.					
	The policy inclu						
		cations in a safe and					
	effective manner						
	[medication adm	ninistration record] for					
	orderRead me	dication label three (3)					
	timesCompare	label to MARAfter					
	administration, r	eturn to careand					
		istration in the MARIf					
		medication, document					
	refusal on MAR	"					
	On 11/16/11 of 0	2:30 A.M., the Director of					
		d the current facility					
		cation Administration					
		al Guidelines," undated.					
		ded: "Unless a specific					
		ed by the attending					
	physician medic						
		the following times: a.					

012448

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155785		(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/16/2011	
NAME OF F	PROVIDER OR SUPPLIER		B. WING STREET	ADDRESS, CITY, STATE, ZIP CODE	
	IVER HEALTH CAM			EICKHOFF RD SVILLE, IN47712	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	in the morning, be and at bedtime, coaround lunch time [four times daily] lunch time, around bedtime The nut the previous dose the same medical provided too closs that have been or [sic] shall be addidesignated by the On 11/16/11 at 9 interview with the indicated there we regarding what "rising" meant. This federal defication/6/11. The facility around the same medical provided too closs that have been or [sic] shall be addidesignated by the same medical provided the same medical provided too closs that have been or [sic] shall be additionally the same medical provided too closs that have been or [sic] shall be additionally the same medical provided too closs that have been or [sic] shall be additionally the same medical provided too closs that have been or [sic] shall be additionally the same medical provided too closs that have been or [sic] shall be additionally the same medical provided too closs that have been or [sic] shall be additionally the same medical provided too closs that have been or [sic] shall be additionally the same medical provided too closs that have been or [sic] shall be additionally the same medical provided too closs that have been or [sic] shall be additionally the same medical provided too closs that have been or [sic] shall be additionally the same medical provided too closs that have been or [sic] shall be additionally the same medical provided too closs that have been or [sic] shall be additionally the same medical provided too closs that have been or [sic] shall be additionally the same medical provided too closs that have been or [sic] shall be additionally the same medical provided too closs that have been or [sic] shall be additionally the same medical provided too closs that have been or [sic] shall be additionally the same medical provided too closs that have been or [sic] shall be additionally the same medical provided too closs that have been or [sic] shall be additionally the same medical provided too closs that have been or [sic] shall be additionally the same medical	after the resident awakes b. BID - in the morning c. TID - in the morning, e and at bedtime, d. QID control of the morning, around and dinner time and at the shall note the time of the prior to administering tion to ensure it is not the togetherMedications and at specific time ministered at the time the attending physician." 2.45 A.M., during the Administrator, she that currently no policy Upon rising" or "After The control of the morning and the mornin			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155785 11/16/2011 WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 714 S EICKHOFF RD WEST RIVER HEALTH CAMPUS EVANSVILLE, IN47712 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5)PROVIDER'S PLAN OF CORRECTION ROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE The facility must ensure that it is free of F0332 medication error rates of five percent or SS=E greater. F0332 F332Resident D's MAR and 11/30/2011 Based on observation, interview, and physician orders were reviewed record review, the facility failed to ensure with RN #1. Staff that administer a medication rate of no greater than 5%, medication to him have been in that a medication rate of 16% was inserviced on these orders as well as being checked off for proper calculated, which affected 4 of 9 residents administration of reviewed during medication pass, in a them.Completion Date sample of 10. there were 7 errors in 42 11-30-11Resident B's MAR has opportunities for error resulting in a 16.66 been reviewed with RN #1. Staff that administer medication to % error rate. Residents D, B, A, and E them and have been checked off for proper administration of these Findings include: meds.Completion Date 11-3-11Resident A's MAR has been reviewed with RN #1. Staff 1. On 11/15/11 at 12:10 P.M., RN # 1 that administer medications have indicated she was going to give Resident been checked off on proper D his "upon rising" medications. RN # 1 administration and the resident indicated Resident D had been in the has been instructed on the dining room at breakfast time, and she correct order for the medication.Completion Date was not allowed to pass medications in 11-30-11Resident E's MAR has the dining room. RN # 1 indicated she been reviewed with RN #1 and "had to compete with therapy "sometimes other staff that administer her to give the resident his medications. meds for check off of proper procedure and as ordered.Completion Date RN # 1 proceeded to prepare medications 11-30-11No other residents were with labels which indicated: Zinc 50 mg affected by the deficient practice in am with breakfast, Glucotrol 5 mg [for and through inservicing and competency completion will blood sugar] in am before breakfast, and ensure that medications are Glucophage 500 mg [for blood sugar] administered as they are ordered before breakfast. The Administrator was and documented notified at that time that RN # 1 was timely.Completion Date 11-30-11Licensed nursing staff preparing to administer the resident these inserviced on proper medication medications, and indicated she would administration procedures and

TN4712

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
AND PLAIN	OF CORRECTION	155785		LDING	00	11/16/2	
		.557.55	B. WIN		DDDECC CITY CTATE 7ID CODE	11,10,2	~··
NAME OF I	PROVIDER OR SUPPLIEF	8			DDRESS, CITY, STATE, ZIP CODE		
WEST R	IVER HEALTH CAN	MPUS .			VILLE, IN47712		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	documentation of		DATE
		r of Nursing [DON]. Prior			completion.Completion Date		
		ring, RN # 1 indicated it give the Glucotrol and			11-30-11DHS/Designee will		
	1	ce "the order says before			observe 1 nurse per day duri		
		is before lunch." The			med administration rotating s and hallways, and fill out	sniits	
		ed, and instructed RN # 1			observation report upon		
		cations, and inform the			completion with identified		
	physician.	cutions, and inform the			concerns related to dosage, technique, timeframes,		
	Pil) Siciali.				documentation, etc. Audits v	vill	
	The clinical reco	ord of Resident D was			be for 15 day, then 1 per wee		
		15/11 at 12:30 P.M.			30 days, then 1 monthly.		
		ded, but were not limited			Pharmacist will also randoml observe 1 nurse med pass p	•	
		Hypertension. Physician			month.Results of audits will b		
		vember 2011, indicated:			forwarded to QA committee		
	•	ve 1 capsule by mouth in		monthly x 6 months and then	l		
		n breakfast, Glucotrol 5			quarterly thereafter.		
		t by mouth in the					
	morning before l	oreakfast for DM					
	[diabetes mellitu	s], Glucophage 500 mg					
	tablet, Give 1 tal	olet by mouth every					
	morning before l	oreakfast."					
		t 9:55 A.M., during a					
	1 * '	RN # 1 was observed to					
		lent B medications. RN #					
		Medication Administration					
		and placed a dot in the					
	I	lication. RN # 1 was not					
		al the boxes after the					
	medication was	administered.					
	On 11/15/11 at 1	0:45 A.M., the clinical					
	record of Reside	nt B was reviewed.					
	Diagnoses include	ded, but were not limited					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155785			LDING	NSTRUCTION 00	(X3) DATE COMPL 11/16/2	ETED	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	Z.			ICKHOFF RD		
WEST R	IVER HEALTH CAN	/IPUS		EVANS'	VILLE, IN47712		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAU	to, History of CV	<u> </u>		IAU			DATE
	1 '	Physician's order,					
		10/11 and on the current					
	1 -	orders, indicated,					
	"Norvasc 5 mg (Give 1 tablet by mouth					
	daily upon rising	g for HTN					
	1	RN # 1 had not been					
		inister the Norvasc with					
		ation pass. The MAR					
		that time, and none of the					
	_	dications were initialed					
	as given.						
	On 11/15/11 at 1	2:30 P.M., during					
		N # 1, she did not					
		nation regarding why the					
	Norvasc had not						
		t 10:40 A.M., during					
		medication pass, RN # 1					
		administer medications					
		ne of the medications					
		50 inhaler, in which the					
		1 puff every 12 hours."					
		inhaler to the resident, proceeded to give himself					
	2 puffs of the inl						
	2 paris or the fin	14101.					
	The clinical reco	ord of Resident A was					
	reviewed on 11/2	15/11 at 11:35 A.M. A					
	physician's order	; initially dated 8/19/11					
		nt November 2011 orders,					
		ir 100/50 Give 1 puff					
	orally every 12 h	nours." The resident's					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155785		A. Bl	MULTIPLE CO UILDING ING	NSTRUCTION 00		(X3) DATE COMPI 11/16/2	LETED	
NAME OF F	PROVIDER OR SUPPLIER		P. W		ADDRESS, CITY, STA	ATE, ZIP CODE		
					ICKHOFF RD			
	VER HEALTH CAN				VILLE, IN47712			
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NOVEY MUST BE PERCEDED BY FULL		ID PREFIX		PLAN OF CORRECTION /E ACTION SHOULD BE		(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCE	ED TO THE APPROPRIAT FICIENCY)	E	DATE
	MAR was review	wed at that time, and						
	indicated the res	ident was to receive the						
	inhaler "Upon ris	sing" and "HS" [bedtime].						
		at 2:15 P.M., during						
		medication pass, RN # 1						
		administer Resident E						
	· · · · · · · · · · · · · · · · · · ·	ich included Trental 400						
		disorders]. When RN # 1 lent's room, the resident						
		I not get my Benefiber						
	-	't receive it this morning."						
	_	cked the MAR, and						
		e resident Benefiber 1						
	packet. RN # 1 is	ndicated at that time that						
	she had looked a	at an entry on the MAR						
	which indicated,	"Benefiber, refuses,						
		" and so didn't give it. An						
	1	on the MAR indicated,						
	•	eket BID [with] meals,						
	Breakfast, Suppe	er."						
	The clinical reco	ord of Resident E was						
		15/11 at 2:45 P.M.						
		s on the November 2011						
		ided: "Trental 400 mg po						
		s daily] upon rising,						
	supper, HS," and	d "Benefiber BID [twice						
	daily]."							
	5. On 11/15/11 a							
	•	rovided the current facility						
	policy on "Speci							
		Procedures," dated 2/1/10.						
FORM CMS-2	567(02-99) Previous Version	ons Obsolete Event ID:	TN471	2 Facility I	D: 012448	If continuation sh	eet Pa	ge 11 of 17

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155785				LDING	NSTRUCTION 00		(X3) DATE COMPL 11/16/2	ETED
NAME OF I	PROVIDER OR SUPPLIER	1			DDRESS, CITY, STA	TE, ZIP CODE	1	
					CKHOFF RD			
	IVER HEALTH CAN	MPUS		EVANSV	/ILLE, IN47712			
(X4) ID		TATEMENT OF DEFICIENCIES		ID		AN OF CORRECTION E ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL CLSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCE	D TO THE APPROPRIAT CIENCY)	ΤE	COMPLETION DATE
1710	The policy include	<u> </u>		1710		·		DATE
		cations in a safe and						
	effective manner							
		ninistration record] for						
	_	edication label three (3)						
		label to MARAfter						
	•	eturn to careand						
	· · · · · · · · · · · · · · · · · · ·	nistration in the MARIf						
	resident refuses	medication, document						
	refusal on MAR.	•						
	On 11/16/11 at 9	9:30 A.M., the Director of						
	Nursing provide	d the current facility						
	policy on "Medio	cation Administration						
	Times Procedura	al Guidelines," undated.						
	The policy inclu-	ded: "Unless a specific						
	time is designate	ed by the attending						
	physician medica	ations shall be						
	administered at t	the following times: a.						
		- after the resident awakes						
	J	b. BID - in the morning						
		e. TID - in the morning,						
		ne and at bedtime, d. QID						
	_] - in the morning, around						
		nd dinner time and at						
		irse shall note the time of						
	-	e prior to administering						
		ition to ensure it is not						
	•	se togetherMedications						
		rdered at specific time						
		ninistered at the time						
	designated by the	e attending physician."						
	On 11/16/11 + 0	0.45 A.M. danier						
		9:45 A.M., during						
FORM CMS-2	567(02-99) Previous Version	ons Obsolete Event ID:	TN4712	Facility II	D: 012448	If continuation sh	neet Pa	ge 12 of 17

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155785		LDING	NSTRUCTION 00	(X3) DATE COMPL 11/16/2	ETED	
	PROVIDER OR SUPPLIER		 714 S E	ADDRESS, CITY, STATE, ZIP CODE		
	VER HEALTH CAN			VILLE, IN47712		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
	interview with the indicated there we regarding what "rising" meant.			CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	

NAME OF PROVIDER OR SUPPLIER WEST RIVER HEALTH CAMPUS IVAI ID SIMMARY STATEMENT OF DEFICIENCIES REFER TAG REGIT ATORY OR LSC IDENTIFYING INFORMATION) STREET ADDRESS, CITY, STATE, JIP CODE THE SELECKHOFF FOR DE EVANSVILLE, IN47712 ID RECHT DETICATION REGIT ATORY OR LSC IDENTIFYING INFORMATION) TAG REGIT ATORY OR LSC IDENTIFYING INFORMATION) TAG (X.S.) REGIT ATORY OR LSC IDENTIFYING INFORMATION) TAG REGIT ATORY OR LSC IDENTIFYING INFORMATION)	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155785		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING B. WING						
WEST RIVER HEALTH CAMPUS (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION CROSS-REFERENCED TO THE APPROPRIATE	NAME OF P	NAME OF PROVIDER OR SUPPLIER							
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE									
	PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	TE			

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155785	(X2) MU A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE : COMPL 11/16/2	ETED
NAME OF PROVIDER OR SUPPLIER WEST RIVER HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 714 S EICKHOFF RD EVANSVILLE, IN47712				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
F0441 SS=D	The facility must en Infection Control F a safe, sanitary arand to help prevent transmission of diaser and to help prevent transmission of diaser and to help prevent transmission of diaser and to help prevent facility must be program under who will be prevent the spreamust isolate the recommunicable displayed by the program under who will be program under the program under who will be program	restablish and maintain an Program designed to provide and comfortable environment and the development and sease and infection. Tol Program establish an Infection Control anich it - controls, and prevents acility; concedures, such as a applied to an individual cord of incidents and related to infections. Tead of Infection ention Control Program resident needs isolation to do finfection, the facility esident. Test prohibit employees with a lease or infected skin at contact with residents or contact will transmit the est require staff to wash their direct resident contact for ang is indicated by accepted		TAU			DATE
		andle, store, process and o as to prevent the spread of	F0	441	F441Res C suffered no ill ef from the findings on the 256 and licensed staff have beer inserviced on proper PICC flushing.Completion Date 11-30-11There were no other	7L 1	11/30/2011

STATEMENT OF DEFICIENCIES				(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER: 155785		LDING	00	11/16/2	
		100700	B. WIN		DDDECC CITY CTATE 7ID CODE	11/10/2	011
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE		
WEST RIVER HEALTH CAMPUS			714 S EICKHOFF RD EVANSVILLE, IN47712				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIDE DEFICIENCY)	TE COMPLETION DATE	COMPLETION	
TAG		ation, interview, and		TAG	residents affected by the alle	ned	DATE
		ne facility failed to ensure			deficient practice and through		
	staff correctly flu	•			alterations in processes and		
	1	erted central catheter]			inservicing will ensure correct	:t	
		d lead to the potential for			actions to prevent spread infection are followed.Completion		
	· ·	of 1 residents reviewed			Date 11-30-11Nursing staff vinserviced on proper PICC flushing to prevent spreading infection. Systemic changes	will be	
	•	medications, in a sample					
	of 10. Resident (_					
		-			be that nursing staff will use		
	Findings include	c			separate syringes for each p		
	On 11/15/11 at 11:10 A.M., RN # 1 indicated she was going to administer an				flush. Return demonstration	of	
					skill will be documented.Completion Dat	e	
					11-30-11DHS/Designee will		
		medication to Resident			monitor resident medicatio		
	C. A PICC line v	was observed in Resident			administration that includes F flushing techniques daily x 5	PICC	
	C 's right arm, w	hich had 2 separate ports,			days, 3 x week for 2 weeks, f	then	
	or lumens. RN #	1 proceeded to flush			weekly with results of compli-	ance	
	each of the ports	with 5 cc normal saline,			being forwarded to QA comn		
	using the same s	yringe. When interviewed			monthly x 6 months and quanthereafter.	rteriy	
	at that time, RN	# 1 indicated, "I use a					
	10cc syringe, and	d flush each port with half					
	of the normal saline. " On 11/15/11 at 1:45 P.M., the Director of Nursing provided the current facility policy on "Flushing IV Access Devices," undated. The policy included:						
	_	[PIV]2-3cc of N/S					
	[normal saline] b						
		e and PICC's: (flush each					
		r even when not in use),					
		me as PIV's except use					
	10cc syringes an	d 3-5cc of N/S"					

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155785	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/16/2011		
NAME OF PROVIDER OR SUPPLIER WEST RIVER HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 714 S EICKHOFF RD EVANSVILLE, IN47712				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
TAG	On 11/15/11 at 1 interview with the indicated it would	:50 P.M., during ne Administrator, she d be standard nursing se the same syringe to	TAG	DEFICIENCY)	DATE		